CARE to CARE
MULTI-SPECIALTY MANAGEMENT

485 Madison Avenue - Suite 202
New York, NY 10022

Phone: 212-747-1000
Fax: 212-867-3371

PHYSICIAN CREDENTIALING APPLICATION

CREDENTIALING CHECKLIST

Primary Facility Name: ______________________________

Physician Name: ______________________________

(Please duplicate this page for every physician to be credentialed)

CREDENTIALING CONTACT INFORMATION

Name: ______________________________

Phone #: ______________________________

E-Mail: ______________________________

PHYSICIAN INFORMATION

- ☐ Roster of all reading physician radiologists and copies of the following documents:
- ☐ Current CV indicating current practice locations (**in month/year format**)
- ☐ Medical School Diploma
- ☐ ECFMG Certificate or Fifth Pathway Certificate (if applicable)
- ☐ Copy of current DEA License and/or State Narcotics License (if applicable)
- ☐ Copy of current State Medical License
- ☐ Copy of current Board Certification(s)
- ☐ Copy of current Malpractice Coverage
- ☐ Copy of Hospital Affiliation Letter

PLEASE SUBMIT APPLICATION AND ALL SUPPORTING DOCUMENTS TO:

Care to Care
485 Madison Avenue - Suite202
New York, NY 10022
Attn: Credentialing Dept.

Fax #: (212) 867-3371
Email: credentialing@caretocare.com

Phone #: (888) 836-3899

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MULTI-SPECIALTY MANAGEMENT

PHYSICIAN CREDENTIALING INFORMATION

Primary Facility Name:			
Primary Facility Address:			
Primary Facility City, State, Zip:		Facility TIN#:	

If physician is affiliated with multiple facility locations, please attach a list of all affiliated facility locations.

Physician Name:		Check One:	☐ MD ☐ DO
Social Security #:		Date of Birth:	
Place of Birth (State and Country):		Gender:	☐ F ☐ M
Medical License # & State:		Exp. Date:	
Medical License # & State:		Exp. Date:	
Medical License # & State:		Exp. Date:	
Medical License # & State:		Exp. Date:	
Individual NPI#:		CAQH #:	
Medicare #:		Medicaid #:	
Current DEA # and State: (if applicable)		Exp. Date:	
State-specific narcotic/controlled substance license # and State: (if applicable)		Exp. Date:	
Medical School:		Start Date:	
		Grad. Date:	
ECFMG Certificate # (if applicable):			

Specialty:		Board Certified?	☐ Y ☐ N	Exp:	
Specialty:		Board Certified?	☐ Y ☐ N	Exp:	
Specialty:		Board Certified?	☐ Y ☐ N	Exp:	

Practicing Specialty: (Please describe scope of practice)			
Malpractice Policy Carrier:			
Limits of Liability:		Policy Coverage Dates:	

Hospital Affiliations			
Hospital Name:		Status:	
From (mm/yy):		To (mm/yy):	

PHYSICIAN MANDATORY QUESTIONNAIRE

Physician Name: ______________________________

Primary Facility Name: ______________________________

Primary Facility Address: ______________________________

EDUCATION AND TRAINING	
During your education, internship, residency, fellowship preceptorship or additional training (as applicable) were you ever disciplined, suspended, placed on probation, formally reprimanded, or asked to resign?	☐ Yes ☐ No
BOARD CERTIFICATION	
Has your Specialty Board certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended, or reduced – or have any proceedings toward those ends been instituted?	☐ Yes ☐ No
LICENSE INFORMATION *(FOR THE PURPOSE OF THIS QUESTIONNAIRE, "STATE" ALSO INCLUDES ANY DISTRICT, TERRITORY OR PROVINCE.)*	
1. Have you ever been disciplined, reprimanded, or fined by any state board of medical examiners, professional conduct board, or state or federal agency that disciplines physicians or allied health professionals?	☐ Yes ☐ No
2. Has your license to practice, in your profession, ever been denied, limited, suspended, revoked, or subject to probation or any conditions or limitations in any state?	☐ Yes ☐ No
3. Have you ever been disciplined, suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health program (for example, Medicare, Medicaid), professional society or managed care organization – or is any such action pending?	☐ Yes ☐ No
4. Have you ever been the subject of an investigation by any private, federal, or state health program – or is any such action pending?	☐ Yes ☐ No
5. Have your federal DEA and/or State Controlled Dangerous Substances (CDS) Certificate(s) ever been voluntarily or involuntarily limited, suspended, revoked, relinquished, or not renewed – or are proceedings currently pending?	☐ Yes ☐ No
INSURANCE INFORMATION	
1. How long have you been insured with your current professional liability insurance carrier? ➢ If under five (5) years, provide name/address and length of coverage for previous carrier to include a five (5) year period:________________________	______YEARS ______YEARS
2. Has your professional liability insurance coverage ever been terminated or modified by action of an insurance company?	☐ Yes ☐ No
3. Have you ever been denied professional liability insurance coverage or rated in a higher-than-average risk class for your specialty?	☐ Yes ☐ No
4. Have any professional liability suits, actions or claims alleging malpractice ever been filed against you?	☐ Yes ☐ No
5. Are any professional liability suits, actions or claims currently pending against you?	☐ Yes ☐ No
6. Have any judgments ever been made against you in professional liability cases or claims, or have you ever entered into any settlements?	☐ Yes ☐ No
7. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?	☐ Yes ☐ No
8. Are you currently uninsured for professional liability (malpractice insurance) coverage?	☐ Yes ☐ No

PHYSICIAN MANDATORY QUESTIONNAIRE (CONTINUED)

Physician Name: ______________________________

Primary Facility Name: ______________________________

Primary Facility Billing Address: ______________________________

HOSPITALS AND OTHER AFFILIATIONS		
1. Have your clinical privileges at any hospital or healthcare institution or organization ever been limited, suspended, revoked, not renewed, or subject to probationary or other disciplinary conditions, or have proceedings toward any of these ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?	YES ☐	NO ☐
2. Has your request for any specific clinical privileges been denied or granted with stated limitations (aside from ordinary or initial requirements of proctorship), or has a medical staff or peer review committee recommended to a governing board such a denial or limitation?	YES ☐	NO ☐
3. Have you ever had any challenges to, or voluntarily or involuntarily relinquished any medical staff membership clinical privilege(s), as a result of any investigation or disciplinary action?	YES ☐	NO ☐
4. Have you ever been court-martialed, sanctioned, reprimanded, or cautioned by a hospital or any other healthcare facility or military agency; been involuntarily terminated or forced to resign; or have you resigned voluntarily while under investigation or threat of sanction from a hospital or healthcare facility or military agency?	YES ☐	NO ☐
HEALTH STATUS		
1. Are you currently using any illegal drugs?	YES ☐	NO ☐
2. During the last three years have you ever been under the influence of alcohol during working hours, or have you used drugs illegally?	YES ☐	NO ☐
3. Are you unable, with or without reasonable accommodation, to practice to the fullest extent of your license, qualification, and privileges without in any way posing a risk of harm to your patients?	YES ☐	NO ☐
CRIMINAL HISTORY		
1. Have you ever been arrested for, or charged with, a crime involving children? ➢ If "Yes," include the disposition of the arrest or charge on a separate sheet. This statement is being answered under penalty of perjury, subject to applicable Federal punishment for perjury.	YES ☐	NO ☐
2. Have you ever been convicted of a felony or are you presently under investigation or have you ever been indicted for a felony?	YES ☐	NO ☐

If you have answered "Yes" to any of the questions above, please attach an explanation for each answer including for each claim, please complete the attached Professional Claims History Form providing an explanation of liability actions, or settlements made on your behalf. Please note that you are encouraged to report all claims regardless of status (i.e. pending, dismissed/discontinued, settled, etc) as any omissions may delay the processing of your application as well as complicate routine re-credentialing process in the future.

PHYSICIAN ATTESTATIONSTATEMENT

Physician Name: ______________________________

Primary Facility Name: ______________________________

Primary Facility Billing Address: ______________________________

E-Mail: ______________________________

I hereby authorize Care to Care IPA, LLC and its agencies to consult with administrators and members of medical staffs of hospitals, malpractice carriers and organizations with which I have been associated, who may have bearing on my qualifications. I further consent to inspection of all records and documents that may be material to my evaluation. I agree to abide by the terms of the Agreement with Care to Care IPA, LLC, as well as the policies that may be adopted by Care to Care IPA, LLC concerning the conditions, criteria, and standards of participation in the provider panel.

I shall provide immediate notice to Care to Care IPA, LLC of any circumstance that limits any of my abilities to provide the Radiological services as outlined in the application.

I,________________________________(print name) am a___________________ (indicate specialty) providing services at _ ____ (facility name) at____ (facility address). I am duly licensed in the State in which I practice. I am Board Certified/Board Eligible in my specialty. By the signature below, I hereby attest that all information contained herein is complete and accurate. And, I agree to provide information as requested to support thisapplication.

X____

Signature of MD

____ ____________________________________

Title Date